Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FRWY SUITE 2200
HOUSTON TX 77027

Respondent Name

COMMERCE & INDUSTRY INSURANCE

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-0528-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated September 21, 2007: "It is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. AIG issued an underpayment of $174,930.12 as a fair and reasonable reimbursement for emergency, trauma, and burn admits."

Requestor's Supplemental Position Summary dated December 12, 2011: "Enclosed please find the Curriculum Vitae and Affidavit of Patricia L. Metzger, Chief of Care Management for Memorial Hermann. Ms. Metzger has extensive knowledge of medical care, treatment plans, and inherently complicated surgical procedures which would require extensive services and supplies by hospital providers. With respect to this case, Ms. Metzger unequivocally states that the medical services and supplies provided to the patient were complicated and extensive."

Amount in Dispute: $154,378.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor claims entitlement to additional payment on this trauma/burn admission. Carrier paid fair and reasonable at $174,092.62. Requestor claims entitlement to additional payment but does not indicate the basis for that payment other than speaking in terms of percentage of billed charges. This is no standard or legal basis for payment in Texas."

Response Submitted by: Commerce & Industry Insurance Co., FOL, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2006 Through November 21, 2006	Inpatient Services	$154,378.13	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on September 24, 2007.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits (EOBs) dated December 11, 2006
   - 42-Charges exceed our fee schedule or maximum allowable amount.
   - I011-Billed charges adjusted to usual and customary allowance and geographic location.
   - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 945.39. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "It is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. AIG issued an underpayment of $174,930.12 as a fair and reasonable reimbursement for emergency, trauma, and burn admits."
   - The requestor's supplemental position statement asserts that "With respect to this case, Ms. Metzger unequivocally states that the medical services and supplies provided to the patient were complicated and extensive."
   - In support of the requested reimbursement, the requestor submitted an affidavit from Ms. Metzger. However; review of the affidavit finds that the submitted information does not support the requested reimbursement amount or the reimbursement methodology proposed by the requestor.
   - The requestor did not discuss or explain how it determined that reimbursement of the entire amount billed would yield a fair and reasonable reimbursement.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs

of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/20/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		1/20/2012
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.